

80 B Veterans Blvd Pueblo of Acoma, New Mexico, 87034

PO Box 40 San Fidel, New Mexico 87049

Telephone (505) 552-5300 ~ Fax (505) 552-5478

Patient Responsibilities:

By receiving care at *Haak'u Health Center (HHC)*, I acknowledge that I have been informed of and understand the following responsibilities:

- 1. Provide Accurate Information:** I agree to provide complete and truthful information about my health, medications, allergies, medical history, and any changes to my condition or personal information including changes in insurance.
- 2. Participate in My Treatment Plan:** I agree to ask questions when I do not understand instructions and to follow the treatment plan developed with my healthcare provider.
- 3. Communicate Openly:** I will inform my provider if I cannot follow parts of my treatment plan or if I experience unexpected changes or side effects.
- 4. Show Respect for Staff, Patients, and Community:** HCC is a place of healing, and I will treat HHC staff, patients, and visitors with courtesy and respect and refrain from disruptive or threatening behavior both verbal and physical.
- 5. Maintain Appointments:** I will attend scheduled appointments and notify HHC as early as possible if I need to cancel or reschedule.
- 6. Accept Responsibility for My Healthcare Decisions:** I understand there may be consequences of choosing to decline recommended treatment or not following medical advice.
- 7. Safeguard Personal Belongings:** I am responsible for my own belongings while at HHC.
- 8. Follow HHC Policies and Safety Guidelines:** I will follow infection-control measures, facility rules, visitor guidelines, and safety procedures.

Haak'u Health Center

Form 5

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9. Fulfill Financial Responsibilities: I agree to provide accurate insurance information and pay any co-pays, deductibles, or balances owed.

Acknowledgment of Understanding

I acknowledge that:

- I have received and reviewed the *Haak'u Health Center Patient Responsibilities Policy*.
 - I understand my role in supporting safe, respectful, and effective care.
 - I may ask questions at any time if I need clarification.
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Patient Name: _____ **DOB:** _____ **Chart :** _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____ **Date:** _____

HHC Staff Signature: _____ **Date:** _____